

was found between years of pitching experience and any elbow symptoms or problems.

Larson and associates² examined 120 pitchers ages 11 and 12 in Eugene, Oregon. There were no statistically significant correlations or interrelations found regarding pitching experience, symptoms, elbow deformities or x-ray findings. The authors concluded that "pitching demands in Eugene have not been demonstrated to be detrimental to the immature throwing arms."

Responding to concern about the possibility that adverse effects might be delayed in their appearance, Francis and associates³ studied 328 Brigham Young University students who had played youth-league baseball, and compared them with 70 students with no previous baseball experience. No significant difference was seen in incidence of residual damage, or in residual injury among positions played or years of experience. The conclusion was that "participation in organized baseball as an adolescent has no enduring deleterious effect on the throwing elbow."

Likewise, Grana and Rashkin⁴ studied 73 Oklahoma City senior high school pitchers. No significant relationships were found between occurrence of symptoms and number of seasons played, individual pitching traits, asymmetry on physical examination or asymmetry on x-ray examination of the elbow.

In other words, recent studies tend to contradict the widely held belief that pitching a baseball imposes significant risk of enduring damage to a young player's elbow.

STUART CHARLES GOLDSTEIN, MD
Danville, California

REFERENCES

1. Gugenheim JJ, Stanley RF, Woods GW, et al: Little League survey: The Houston study. *Am J Sports Med* 1976 Sep/Oct; 4:189-200
2. Larson RL, Singer KM, Bergstrom R, et al: Little League survey: The Eugene study. *Am J Sports Med* 1976 Sep/Oct; 4:201-209
3. Francis R, Bunch T, Chandler B: Little league elbow: A decade later. *Phys Sportsmed* 1978 Apr; 8:8-94
4. Grana WA, Rashkin A: Pitcher's elbow in adolescents. *Am J Sports Med* 1980 Sep/Oct; 8:333-336

CSN Codes for Specialized Occupational Medicine Services

TO THE EDITOR: The excellent collection of articles on occupational medicine topics in the December 1982 issue will be a stimulus to the provision of occupational medicine services by providers in the West. We recently proposed a set of model service codes for specialized occupational medicine services compatible with the format of the 1974 revision of the California Relative Value Studies (RVS)¹ and are using it for routine billing and administrative procedures. We propose it as a standard for other medical groups and for possible inclusion into the planned update of the California Standard Nomenclature (CSN) directed by the 1981 House of Delegates of the California Medical Association.

The majority of clinical services provided by occupational medicine practitioners are comparable to those already encoded in the CSN, differing only in the cognitive skills of the practitioner. A few common services are unique to occupational medicine, however, because they pertain to on-site plant visits, extensive consultations with employers, and urgent consultations to deal with a hazardous situation or other problem. These services have no identifiers in the present CSN, but occur sufficiently often to require a code number for billing and data management purposes.

The 1974 RVS has a gap in the numerical sequence in the 98000 series; these numbers are also unused in the AMA Current Procedural Terminology. Why this gap exists is not known, but its placement just before the "Special Services" section is very fortunate. We developed a coding system within the 98000 sequence (Table 1) which is based on the following scheme: The third digit represents *activity* (0=exploratory discus-

TABLE 1.—Proposed Numerical Codes for Specialized Occupational Medicine Services, Compatible With CSN

Suggested Code	Name of Service	Description of Service
98001	Initial On-Site Consultation	Visit to client's location to ascertain client's needs, requiring approximately 1 hour.
98011	Initial Office Consultation	Visit by client to provider's office to ascertain client's needs, requiring approximately 1 hour.
98101	Consultation Visit, On-Site	Visit to client's location to evaluate a particular problem.
98131	Routine Telephone Consultation	Telephonic consultation concerning an uncomplicated problem, approximately 30 minutes duration.
98201	Health Hazard Evaluation	Extensive survey and evaluation of problem, may require team of professionals.*
98301	Follow-Up, Limited	Visit to plant to evaluate progress, approximately 3 hours.
98302	Follow-Up Evaluation	Visit to plant to assess progress in a complex situation.
98401	Emergency Visit, On-Site	Visit on short notice to client's location to assist with problem which is urgent.
98431	Emergency Telephone Consultation	Telephonic consultation on an urgent problem not requiring presence on-site, approximately 30 minutes.
98501	Instructional Visit, On-Site	Visit to client's location to arrange or present a scheduled instructional program.
98921	Consultation Service	Time spent in research, report preparation, or conceptualizing approach and solution to problem.

*Members of such a team may include industrial hygienists, safety engineers, epidemiologists, toxicologists, and specialized technical personnel as appropriate.

sion, 1 = consultation, 2 = health hazard evaluation, 3 = follow-up, 4 = emergency, 5 = scheduled activity such as an educational presentation, 9 = research and literature review). The fourth digit represents *location* (0 = client's site, 1 = medical facility, 2 = information resource such as a library or data bank, 3 = telephonic communication). The fifth digit is a specific identifier. This scheme has been flexible enough to cover all situations we have encountered but has ample latitude for expansion. The codes are now programmed into our computer and can be independently adjusted for changes in fee schedule.

We urge that the obsolete code 99060 "environmental intervention" be abandoned as inadequate for describing occupational medicine services and that a system similar to ours be considered for inclusion into CSN. Incidentally, codes already exist for multiphasic health testing (99090) and administration of a programmed medical interview (99095).

TEE LAMONT GUIDOTTI, MD, MPH
Occupational/Industrial Medicine Service
The Rees-Stealy Medical Group
San Diego

REFERENCES

1. Committee on Relative Value Studies, California Medical Association. California Relative Value Studies: 1974 Revision. San Francisco, Sutter Publications, 1975

Kaposi's Sarcoma of the Rectum

TO THE EDITOR: Unlike the classic form of Kaposi's sarcoma, which occurs most frequently in elderly men and is characterized by nodules on the lower extremities, the cases now being seen in connection with the acquired immune deficiency syndrome (AIDS) are occurring in much younger (often homosexual) men and lesions may be found on any part of the body. As Dr Robert L. Modlin points out in the June 1983 issue, "Skin lesions can present as single or multiple reddish purple macules, nodules or plaques on any location of the skin or mucous membranes."¹ Fever, weight loss, diarrhea and lymphadenopathy in many cases precede appearance of lesions. The purpose of this brief report is to make clinicians aware of the variable presentation of the disease, as well as noting a specific case.

Report of a Case

A 43-year-old gay, white businessman was seen in May 1983 in surgical consultation for rectal bleeding of three to four months' duration. The bleeding was apparent only at the time of bowel movements and consisted of 5 to 20 ml (patient's estimate) of dark red blood with small amounts of bright red blood. There was no discomfort. About six months earlier the patient had noted the onset of night sweats, daily temperature spikes as high as 39°C (102°F), recurrent episodes of bronchitis, episodic diarrhea due to enteric pathogens (which was treated) and extreme fatigue. There was no weight loss. He had recovered from hepatitis four years before.

On physical examination no lymphadenopathy was noted other than a few shotty inguinal nodes. The liver edge was palpable but smooth and nontender. The spleen was not palpable. There was a fine miliary light pink skin rash predominately on the extremities. This was asymptomatic.

Digital rectal examination revealed two lesions on the anterior wall just proximal to the mucocutaneous line. These were very firm to palpation—somewhat more so than a scirrhous carcinoma. On endoscopy the larger lesion was 0.5 by 0.5 by 5 cm and "pillar-like" in gross appearance. There was a smaller satellite lesion. These were on the mucosa, freely movable and bled easily when touched with a cotton-tipped applicator. They were a deep purple in color. Chest x-ray films, a barium enema study and sigmoidoscopy showed no additional abnormalities. Aspartate aminotransferase (formerly designated SGOT), alanine aminotransferase (SGPT), lactic dehydrogenase and alkaline phosphatase were elevated but minimally so. A VDRL test was nonreactive. The lesions were excised along with a cuff of normal appearing mucosa. Examination by the Department of Pathology, St Francis Hospital, San Francisco, showed them to be Kaposi's sarcoma. The patient was thereafter referred to appropriate facilities at the University of California, San Francisco.

JOHN L. BRADIN, Jr, MD
San Francisco

REFERENCE

1. Modlin RL: Kaposi's sarcoma: Current trends (Epitomes of Progress). *West J Med* 1983 Jun; 138:862-863